The Center
for Christian Counseling, Consultation & Training, Inc.

4868 High Crossing Blvd.
Madison, WI 53704
608.274.8294
608.274.8783 Fax

CLIENT INFORMATION FORM

Please answer the following questions thoroughly (both sides). It is very important that you bring this completed form to your first counseling session.

Client Name: ____ Date: ___________________________

PHYSICAL HEALTH STATUS (Medical, physiological)

List current medical conditions (arthritis, diabetes, etc.) ____
____

Any areas of functional impairment? _ ____
____

List all prescribed medications, over-the-counter medications, natural/herbal supplements, vitamins, minerals that you are currently taking. If needed, please attach an additional sheet:

Drug/Supplement	Purpose	Dose	Start Date

Prescribing Physician: __________________________

What medications have you tried in the past and why where they stopped? ________________________
____

LIFE STYLE & VALUES

Do you exercise regularly? Yes No Please explain: ____
How many hours do you sleep at night? ____ Do you sleep well? Please explain: ___________________
____

Do you place importance on what you eat and drink? Please describe: ____________________________
____

Do you struggle with any compulsive/addictive behaviors (such as sex, pornography, food, gambling, work, caffeine, nicotine, alcohol, other legal or illegal drugs)? Please describe use & frequency:
____
____

If you struggle with any compulsive/addictive behaviors, how are they impacting your life? ___________
____

What are your hobbies and interests? ____
____

Important values for you? ____
Current priorities for you? ____

FAMILY

Many families today have very complex family histories which we can discuss in more detail when we meet. The following questions will be a helpful starting point regarding your family history:
Mother's name and age: __________________ ( ) Father's name and age: ___________________ ( )
List the names and ages of your brothers and sisters: ____
____

4868 High Crossing Blvd.
Madison, WI 53704
608.274.8294
608.274.8783 Fax

The Center
for Christian Counseling, Consultation & Training, Inc.

PERTINENT DEVELOPMENTAL HISTORY

Were there things that happened to you when you were growing up that you felt were particularly significant in your life? Any trauma? Please elaborate: ____

____

FAMILY & COMMUNITY SUPPORT (Social)

List any support systems that have been and are helpful to you. Include family members, friends and organizations. ____

____

EMPLOYMENT/SCHOOL

Current occupation: ______________________________ How many hours/week do you work? _______

Previous occupations: ____

How do you feel about your work? ____

____

Are you currently enrolled in school? Yes No If yes, which school and what is your area of concentration? ____

ANY LEGAL ISSUES IN YOUR PAST OR PRESENT SITUATION (Be specific) ______________

____

____

SPIRITUALITY

Do you consider yourself a spiritual person? Yes No Please explain: ___________________________

____

Do you attend church regularly? Yes No If yes, what church? _______________________________

Pastor: ______________________________

List any special ministries, Bible studies, church activities, etc. that you are active in: _______________

____

Do you pray regularly? Yes No Comments: ____

How would you like your spirituality acknowledged in counseling sessions? _______________________

____

PAST COUNSELING When? With whom? Was it helpful? ____________________________________

____

____

SELF-ASSESSMENT (Experience)

Describe how you see yourself and your life at this time. *(If needed, attach an additional sheet)*

____

____

List your current strengths, challenges or trauma and your current needs. *(Attach additional sheet if needed)*

____

____

THERAPY GOALS (Recovery Goals)

How do you hope to be different when your work in therapy is finished? Be specific. _______________

____

____